

		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0041871</u></p> <p>Facility Name: <u>Provena St. Joseph Center</u></p> <p>Address: <u>659 E. Jefferson</u> <u>Freeport</u> <u>61032</u> Number City Zip Code</p> <p>County: <u>Stephenson</u></p> <p>Telephone Number: <u>(815)232-6181</u> Fax # ()</p> <p>IDPA ID Number: <u>371127787011</u></p> <p>Date of Initial License for Current Owners: <u>07/01/96</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501c3</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Lynda Olinski</u> Telephone Number: <u>(708)478-7916</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501c3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/31/03</u> to <u>12/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1159 743 1314 911" rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Michael R Gordon</u></td> </tr> <tr> <td></td> <td>(Title) <u>Vice President</u></td> </tr> <tr> <td data-bbox="1159 911 1314 1149" rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) () Fax # ()</td> </tr> </table> <p align="center"> MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) <u>Michael R Gordon</u>		(Title) <u>Vice President</u>	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____		(Telephone) () Fax # ()
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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STATE OF ILLINOIS

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Facility Name & ID Number Provena St. Joseph Center# 0041871 Report Period Beginning: 1/31/03 Ending: 12/31/03

III. STATISTICAL DATA

D. How many bed-hold days during this year were paid by Public Aid?

38 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)N/A - NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 7/1/1996

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 7/1/1996 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 16 and days of care provided 3,733

Medicare Intermediary _____

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

1		2		3		4	
	Beds at Beginning of Report Period		Licensure Level of Care		Beds at End of Report Period		Licensed Bed Days During Report Period
1	120		Skilled (SNF)		120		43,800
2			Skilled Pediatric (SNF/PED)				
3			Intermediate (ICF)				
4			Intermediate/DD				
5			Sheltered Care (SC)				
6			ICF/DD 16 or Less				
7	120		TOTALS		120		43,800

B. Census-For the entire report period.

1	2	3	4	5	
Level of Care	Patient Days by Level of Care and Primary Source of Payment				
	Public Aid Recipient	Private Pay	Other	Total	
8 SNF	<u>18,112</u>	<u>5,809</u>	<u>3,733</u>	<u>27,654</u>	8
9 SNF/PED					9
10 ICF		<u>12,787</u>		<u>12,787</u>	10
11 ICF/DD					11
12 SC					12
13 DD 16 OR LESS					13
14 TOTALS	18,112	18,596	3,733	40,441	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 92.33%

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

Provena St. Joseph Center

0041871

Report Period Beginning:

1/31/03

Ending:

12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	266,626	4,377	26,892	297,895		297,895		297,895			1
2	Food Purchase		149,708		149,708		149,708	2,053	151,761			2
3	Housekeeping	80,447	35,753		116,200		116,200		116,200			3
4	Laundry	107,694	169	7,114	114,977		114,977		114,977			4
5	Heat and Other Utilities			259,353	259,353		259,353	4,095	263,448			5
6	Maintenance	85,647	2,717	72,131	160,495		160,495	590	161,085			6
7	Other (specify):* Pastoral Care/Develop	53,367			53,367		53,367	(35,221)	18,146			7
8	TOTAL General Services	593,781	192,724	365,490	1,151,995		1,151,995	(28,483)	1,123,512			8
	B. Health Care and Programs											
9	Medical Director			11,600	11,600		11,600		11,600			9
10	Nursing and Medical Records	1,638,935	92,066	94,874	1,825,875		1,825,875		1,825,875			10
10a	Therapy			202,084	202,084		202,084		202,084			10a
11	Activities	62,120	924	70	63,114		63,114		63,114			11
12	Social Services	51,657		(64)	51,593		51,593		51,593			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,752,712	92,990	308,564	2,154,266		2,154,266		2,154,266			16
	C. General Administration											
17	Administrative	158,368	1,452	574,496	734,316		734,316	(320,438)	413,878			17
18	Directors Fees											18
19	Professional Services			107,635	107,635		107,635	10,597	118,232			19
20	Dues, Fees, Subscriptions & Promotions			20,831	20,831		20,831	(7,274)	13,557			20
21	Clerical & General Office Expenses		10,329	27,228	37,557		37,557	(8,895)	28,662			21
22	Employee Benefits & Payroll Taxes			614,443	614,443		614,443	39,834	654,277			22
23	Inservice Training & Education			5,952	5,952		5,952	5,635	11,587			23
24	Travel and Seminar			7,653	7,653		7,653	4,151	11,804			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			36,366	36,366		36,366		36,366			26
27	Other (specify):* Bad Debt			58,366	58,366		58,366	(58,366)				27
28	TOTAL General Administration	158,368	11,781	1,452,970	1,623,119		1,623,119	(334,756)	1,288,363			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,504,861	297,495	2,127,024	4,929,380		4,929,380	(363,239)	4,566,141			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification

STATE OF ILLINOIS

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Facility Name & ID Number Provena St. Joseph Center

#0041871

Report Period Beginning:

1/31/03

Ending:

12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			170,770	170,770		170,770	(4,300)	166,470			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							151,283	151,283			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							11,942	11,942			34
35	Rent-Equipment & Vehicles			15,565	15,565		15,565	979	16,544			35
36	Other (specify):*											36
37	TOTAL Ownership			186,335	186,335		186,335	159,904	346,239			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			338,405	338,405		338,405		338,405			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			404,105	404,105		404,105		404,105			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,504,861	297,495	2,717,464	5,519,820		5,519,820	(203,335)	5,316,485			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Provena St. Joseph Center

0041871

Report Period Beginning: 1/31/03

Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(6,926)	30		9
10	Interest and Other Investment Income	(7)	32		10
11	Discounts, Allowances, Rebates & Refunds	(12,206)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(58,366)	27		24
25	Fund Raising, Advertising and Promotional	(12,399)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (89,904)		\$	30

OHF USE ONLY

48		49		50		51		52	
----	--	----	--	----	--	----	--	----	--

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(47,183)	VAR	34
35	Other- Attach Schedule	(66,248)	VAR	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (113,431)		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (203,335)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Development - Salaries	\$ (35,221)	7	1
2	Development - Dues	(280)	20	2
3	Development- Benefits	(2,177)	22	3
4	Development - Education/Conf	(492)	23	4
5	Development - Supplies	(28)	17	5
6	Development - Misc. Net Assets Released	(23,551)	17	6
7	Development - Gifts	(322)	17	7
8	Development - Events	(1,204)	17	8
9	Development - Postage	(1,099)	21	9
10	Development - Consulting	(900)	19	10
11	Development - Supplies	(795)	21	11
12	Development - Travel	(179)	24	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(66,248)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number **Provena St. Joseph Center**# **0041871**

Report Period Beginning:

1/31/03

Ending:

12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	2,053	0	0	0	0	0	0	0	0	0	2,053	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	4,095	0	0	0	0	0	0	0	0	0	4,095	5
6	Maintenance	0	590	0	0	0	0	0	0	0	0	0	590	6
7	Other (specify):*	(35,221)	0	0	0	0	0	0	0	0	0	0	(35,221)	7
8	TOTAL General Services	(35,221)	6,738	0	0	0	0	0	0	0	0	0	(28,483)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(25,105)	(295,333)	0	0	0	0	0	0	0	0	0	(320,438)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(900)	11,497	0	0	0	0	0	0	0	0	0	10,597	19
20	Fees, Subscriptions & Promotions	(12,679)	5,405	0	0	0	0	0	0	0	0	0	(7,274)	20
21	Clerical & General Office Expenses	(14,100)	5,205	0	0	0	0	0	0	0	0	0	(8,895)	21
22	Employee Benefits & Payroll Taxes	(2,177)	42,011	0	0	0	0	0	0	0	0	0	39,834	22
23	Inservice Training & Education	(492)	6,127	0	0	0	0	0	0	0	0	0	5,635	23
24	Travel and Seminar	(179)	4,330	0	0	0	0	0	0	0	0	0	4,151	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(58,366)	0	0	0	0	0	0	0	0	0	0	(58,366)	27
28	TOTAL General Administration	(113,998)	(220,758)	0	0	0	0	0	0	0	0	0	(334,756)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(149,219)	(214,020)	0	0	0	0	0	0	0	0	0	(363,239)	29

Summary B

12/31/03

[illegible]

Facility Name & ID Number Provena St. Joseph Center # 0041871 Report Period Beginning: 1/31/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food Purchase	\$	Provena Senior Services	100.00%	\$ 2,053	\$ 2,053	1
2	V	3	Housekeeping - Supplies		Provena Senior Services	100.00%	0		2
3	V	5	Heat & Other Utilities		Provena Senior Services	100.00%	4,095	4,095	3
4	V	6	Maintenance - Other		Provena Senior Services	100.00%	590	590	4
5	V	17	Admin Salary Other Admin		Provena Senior Services	100.00%	140,390	140,390	5
6	V	17	Admin - Other	460,788	Provena Senior Services	100.00%	25,065	(435,723)	6
7	V	19	Professional Services		Provena Senior Services	100.00%	11,497	11,497	7
8	V	20	Dues, Fees, Subs & Promotions		Provena Senior Services	100.00%	5,405	5,405	8
9	V	21	Clerical/Genl Supplies		Provena Senior Services	100.00%	3,441	3,441	9
10	V	21	Clerical/Gen - Other		Provena Senior Services	100.00%	1,764	1,764	10
11	V	22	Emp Benefits & Payroll Taxes		Provena Senior Services	100.00%	42,011	42,011	11
12	V	23	Inservic Training & Education		Provena Senior Services	100.00%	6,127	6,127	12
13	V	24	Travel & Seminar		Provena Senior Services	100.00%	4,330	4,330	13
14	Total			\$ 460,788			\$ 246,768	\$ * (214,020)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Provena St. Joseph Center # 0041871 Report Period Beginning: 1/31/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	\$	Provena Senior Services	100.00%	\$ 2,626	\$ 2,626	15
16	V	32	Interest		Provena Senior Services	100.00%	151,290	151,290	16
17	V	34	Rent - Facility & Grounds		Provena Senior Services	100.00%	11,942	11,942	17
18	V	35	Rent - Equipment & Vehicles		Provena Senior Services	100.00%	979	979	18
19	V	17	Admin - Other	82,802	Provena Health	100.00%	82,802		19
20	V	19	Professional Services	58,464	Provena Health	100.00%	58,464		20
21	V	39	Ancillary Service Centers - Other	338,405	Provena Senior Services Pharmacy	100.00%	338,405		21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 479,671			\$ 646,508	\$ * 166,837	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

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Facility Name & ID Number Provena St. Joseph Center # 0041871 Report Period Beginning: 1/31/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Provena St. Joseph Center# 0041871 Report Period Beginning: 1/31/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Provena Senior Services
 Street Address 19065 Hickory Creek Drive, Ste 310
 City / State / Zip Code Mokena, IL60448
 Phone Number (708)478-7900
 Fax Number (708)478-5387

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food Purchase	Mgmt Fee Income	5,373,327	16	\$ 23,945	\$ 460,788	\$ 2,053	1
2	3	Housekeeping - Supplies	Mgmt Fee Income	5,373,327	16	(3)	460,788	0	2
3	5	Heat & Other Utilities	Mgmt Fee Income	5,373,327	16	47,756	460,788	4,095	3
4	6	Maintenance - Other	Mgmt Fee Income	5,373,327	16	6,877	460,788	590	4
5	17	Admin Salary Other Admin	Mgmt Fee Income	5,373,327	16	1,637,117	460,788	140,390	5
6	17	Admin - Other	Mgmt Fee Income	5,373,327	16	292,291	460,788	25,065	6
7	19	Professional Services	Mgmt Fee Income	5,373,327	16	134,066	460,788	11,497	7
8	20	Dues, Fees, Subs & Promotions	Mgmt Fee Income	5,373,327	16	63,031	460,788	5,405	8
9	21	Clerical/Genl Supplies	Mgmt Fee Income	5,373,327	16	40,128	460,788	3,441	9
10	21	Clerical/Gen - Other	Mgmt Fee Income	5,373,327	16	20,574	460,788	1,764	10
11	22	Emp Benefits & Payroll Taxes	Mgmt Fee Income	5,373,327	16	489,898	460,788	42,011	11
12	23	Inservice Training & Education	Mgmt Fee Income	5,373,327	16	71,446	460,788	6,127	12
13	24	Travel & Seminar	Mgmt Fee Income	5,373,327	16	50,497	460,788	4,330	13
14	30	Depreciation	Mgmt Fee Income	5,373,327	16	30,618	460,788	2,626	14
15	32	Interest	Mgmt Fee Income	5,373,327	16	1,764,218	460,788	151,290	15
16	34	Rent - Facility & Grounds	Mgmt Fee Income	5,373,327	16	139,255	460,788	11,942	16
17	35	Rent - Equipment & Vehicles	Mgmt Fee Income	5,373,327	16	11,422	460,788	979	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 4,823,136	\$ 1,637,117	\$ 413,605	25

Facility Name & ID Number Provena St. Joseph Center# 0041871 Report Period Beginning: 1/31/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Provena Health ServicesStreet Address 9223 West St. Francis RoadCity / State / Zip Code Frankfurt, IL 60423Phone Number (815)469-4888Fax Number (815)469-4864

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Admin - Other	Direct Allocation		\$	\$		\$ 82,802	1
2	19	Professional Services	Direct Allocation					58,464	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 141,266	25

Facility Name & ID Number Provena St. Joseph Center# 0041871 Report Period Beginning: 1/31/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Provena Senior Services Pharmacy
 Street Address 1475 Harvard Drive
 City / State / Zip Code Kankakee, IL 60901
 Phone Number (815)928-6141
 Fax Number (815)946-3238

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Ancillary Services - Other	Direct Allocation		\$	\$		\$ 338,405	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 338,405	25

Facility Name & ID Number Provena St. Joseph Center # 0041871 Report Period Beginning: 1/31/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$					\$	9
	B. Non-Facility Related*												
10	Provena Senior Services											151,283	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$ 151,283	14
15	TOTALS (line 9+line14)						\$					\$ 151,283	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Provena St. Joseph Center**# **0041871**

Report Period Beginning:

1/31/03

Ending:

12/31/03**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.

\$

1

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)

\$

2

3. Under or (over) accrual (line 2 minus line 1).

\$

3

4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)

\$

4

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.

(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)

\$

5

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.

TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)

\$

6

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

\$

7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

1998	8
1999	9
2000	10
2001	11
2002	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity
This denial must be no more than four years old at the time the cost report is filed.

A. Square Feet: 51,080

B. General Construction Type: Exterior Brick Frame Number of Stories

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1						\$	1
2							2
3	TOTALS					\$	3

STATE OF ILLINOIS

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Facility Name & ID Number Provena St. Joseph Center

0041871

Report Period Beginning:

1/31/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1996	1994	\$ 2,500,000	\$ 62,500	40	\$ 62,500	\$	\$ 468,750	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1997	38,658	1,486	10	1,486		27,780	9
10	Various			1998	15,953	1,285	10	1,285		14,280	10
11	Various			1999	83,558	6,352	10	6,352		28,583	11
12	DESC: FISCHER EXCAVATING			2000	1,605	321	5	321		1,123	12
13	DESC: ROOF (O'NEIL HALL ARCHIVE R			2000	1,290	258	5	258		903	13
14	DESC: STJ COMMON AREA ASSESSMENT			2000	3,098	620	5	620		2,168	14
15	DESC: HVAC UNIT			2000	1,917	383	5	383		1,342	15
16	DESC: RGB MAJOR BUILDING CONSULTI			2000	5,712	571	10	571		1,999	16
17	DESC: SHOWER (3 PC)			2000	567	81	7	81		284	17
18	DESC: SEALCOAT ASPHALT			2000	4,729	946	5	946		3,310	18
19	DESC: FIX STEAM LEAK			2000	1,729	346	5	346		1,210	19
20	DESC: FIX CONDENSATE LEAK/MAIN BO			2000	538	108	5	108		377	20
21	DESC: ALARM RELAYS, SWITCHES, ETC			2001	2,372	474	5	474		1,186	21
22	DESC: RGB ARCHITECTURAL SERVICES			2001	2,165	433	5	433		1,083	22
23	DESC: RGB ARCHITECTURAL SERVICES			2001	45	15	3	15		38	23
24	DESC: NEW AIR COMPRESSOR			2001	4,042	404	10	404		1,011	24
25	DESC: BATHROOM/KITCHEN REMODELING			2001	5,246	262	20	262		656	25
26	DESC: WATER SOFTENER REPLACEMENT			2001	5,642	564	10	564		1,411	26
27	DESC: REPLACE WATER SERVICE - SLA			2001	932	186	5	186		466	27
28	DESC: NEW WATER MAIN FOR ADC, OLD			2001	6,339	1,268	5	1,268		3,170	28
29	DESC: PATCH HOLE			2001	1,542	308	5	308		771	29
30	DESC: BLACKTOP WORK			2001	2,650	883	3	883		2,208	30
31	DESC: STEAM LINE REPAIRED			2001	1,793	359	5	359		896	31
32	DESC: DRYER			2002	3,295	659	5	659		989	32
33	DESC: ADULT ALL-ADJ STAND-IN TBL			2002	867	58	15	58		87	33
34	DESC: 200 AMP			2002	11,750	1,175	10	1,175		1,763	34
35	DESC: PLUMBING SUPPLIES FOR NEW B			2002	425	28	15	28		28	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number Provena St. Joseph Center

0041871

Report Period Beginning:

1/31/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	DESC: BATHROOM REMODELING	2002	\$ 2,366	\$ 158	15	\$ 158	\$	\$ 158	37
38	DESC: CARPETING FOR BEDROOD AND D	2002	672	134	5	134		202	38
39	DESC: DRAPES	2002	15,414	3,083	5	3,083		4,624	39
40	DESC: ROOF REPAIR	2002	1,800	180	10	180		180	40
41	DESC: REPLACEMENT OF BRICKS ON HA	2002	2,055	103	20	103		154	41
42	DESC: CABINETS AND COUNTER TOPS	2002	1,105	74	15	74		111	42
43	DESC: KITCHEN CABINETS AND WALL B	2002	5,260	351	15	351		526	43
44	DESC: PAINT & MISC SUPPLIES FOR R	2002	800	160	5	160		240	44
45	DESC: CARPETING ADULT DAY CARE OF	2002	477	95	5	95		143	45
46	DESC: REPLACEMENT OF DAMAGED STRE	2002	2,497	166	15	166		166	46
47	DESC: INSTALLATION OF AWNING	2003	2,950	148	10	148		148	47
48	DESC: INSTALLATION OF ELECTRIC BA	2003	751	38	10	38		38	48
49	DESC: DUCTLESS SPLIT SYSTEM FOR O	2003	11,700	390	15	390		390	49
50	DESC: DURO LASST ROOFING SYSTEM	2003			10				50
51	DESC: 4 FT IRON FENCE	2003	2,526	84	15	84		84	51
52	DESC: DURO-LAST ROOFING SYSTEM	2003	21,167	1,058	10	1,058		1,058	52
53	DESC: SAWCUTTING OF CONCRETE ROOF	2003	300	30	5	30		30	53
54	DESC: VINYL POCKET REPLACEMENT	2003	2,343	234	5	234		234	54
55	DESC: A/C COMPRESSOR	2003	3,583	149	12	149		149	55
56	DESC: TRINITY HOUSE ROOF	2003	7,125	356	10	356		356	56
57	DESC: VINYL WINDOW REPLACEMENTS	2003	2,943	210	7	210		210	57
58	DESC: REBUILD HIP & RAFTERS ON FR	2003	5,598	280	10	280		280	58
59	DESC: REWIRE 2ND FLOOR OF O'NIELL	2003	12,500	625	10	625		625	59
60	DESC: UPGRADE SERVICE FOR VILLA H	2003	3,250	163	10	163		163	60
61	DESC: ROOF REMOVAL	2003	4,000	200	10	200		200	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,821,640	\$ 90,803		\$ 90,803	\$	\$ 578,338	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Provena St. Joseph Center # 0041871 Report Period Beginning: 1/31/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 556,448	\$ 64,962	\$ 64,962	\$	10	\$ 393,314	71
72	Current Year Purchases	43,530	2,996	2,996		10	2,996	72
73	Fully Depreciated Assets	34,935					34,935	73
74								74
75	TOTALS	\$ 634,913	\$ 67,958	\$ 67,958	\$		\$ 431,245	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transport	2001 Mercury Sable	2001	\$ 23,123	\$ 7,708	\$ 7,708	\$	3	\$ 19,269	76
77		1997 Dodge 2500	1997	24,090				5	24,090	77
78		Ford Falcon	1998	5,000				3	5,000	78
79										79
80	TOTALS			\$ 52,213	\$ 7,708	\$ 7,708	\$		\$ 48,359	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,508,766 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 166,470 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 166,470 83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,057,942 85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$		86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Provena St. Joseph Center# 0041871Report Period Beginning: 1/31/03Ending: 12/31/03**XII. RENTAL COSTS****A. Building and Fixed Equipment (See instructions.)**1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES☒ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	<u>Allocation - Home Office</u>				<u>11,942</u>			5
6								6
7	TOTAL				\$ 11,942			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized

by the length of the lease _____.

9. Option to Buy: ☐ YES ☒ NO Terms: _____ ***B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES☐ NO16. Rental Amount for movable equipment: \$ 16,544 Description: Nursing \$11,887, Admin \$3,678, Home Office \$979

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____/2004 \$ _____

13. _____/2005 \$ _____

14. _____/2006 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Provena St. Joseph Center # 0041871 Report Period Beginning: 1/31/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES
DURING THIS REPORT
PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder
of this schedule. If "no", provide an
explanation as to why this training was
not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM ☐

IN OTHER FACILITY ☐

COMMUNITY COLLEGE ☐

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM ☐

IN OTHER FACILITY ☐

HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your
facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for
your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses
of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
					Units	Cost				
1	Licensed Occupational Therapist	10a, 3	hrs	\$	1,876	\$ 97,911	\$	1,876	\$ 97,911	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		170	8,876		170	8,876	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs		1,826	95,297	2,010	1,826	97,306	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				338,405		338,405	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	3,871	\$ 202,084	\$ 340,415	3,871	\$ 542,498	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

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Facility Name & ID Number Provena St. Joseph Center# 0041871Report Period Beginning: 1/31/03Ending: 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/03

(last day of reporting year)

This report must be completed even if financial statements are attached

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 8,794,696	\$	1
2	Cash-Patient Deposits	77,816		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	10,376,541		3
4	Supply Inventory (priced at)	485,379		4
5	Short-Term Investments			5
6	Prepaid Insurance	19,788		6
7	Other Prepaid Expenses	803,877		7
8	Accounts Receivable (owners or related parties)	251,746		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 20,809,843	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,263,715		12
13	Land	6,877,199		13
14	Buildings, at Historical Cost	72,927,547		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	13,543,467		16
17	Accumulated Depreciation (book methods)	(39,708,360)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	38,281		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Goodwill</u>	147,576		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 61,089,425	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 81,899,268	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,893,009	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,831,666		28
29	Short-Term Notes Payable	1,152,937		29
30	Accrued Salaries Payable	2,954,499		30
31	Accrued Taxes Payable (excluding real estate taxes)	123,166		31
32	Accrued Real Estate Taxes(Sch.IX-B)	320,867		32
33	Accrued Interest Payable	24,581		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to Related Party</u>	50,095		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 8,350,820	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	41,981,938		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	102,004		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 42,083,942	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 50,434,762	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 31,464,506	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 81,899,268	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 78,679,555	1
2	Restatements (describe):		2
3	2002 Goodwill Write off per Audit	(3,481,389)	3
4	Adj. To Reconcile Consolidated Equity and Consolidated		4
5	Net Income to Nursing Facility Amounts	(43,879,247)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 31,318,919	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	145,587	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 145,587	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 31,464,506	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

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Facility Name & ID Number Provena St. Joseph Center

0041871

Report Period Beginning: 1/31/03

Ending:

12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,695,477	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,695,477	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	364,992	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 364,992	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	46,902	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	310,630	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 357,532	23
	D. Non-Operating Revenue		
24	Contributions	231,557	24
25	Interest and Other Investment Income***	7	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 231,564	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Discounts	12,206	28
28a	Misc. Transportation. Gain/Loss	3,636	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 15,842	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,665,407	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,151,995	31
32	Health Care	2,154,266	32
33	General Administration	1,623,119	33
	B. Capital Expense		
34	Ownership	186,335	34
	C. Ancillary Expense		
35	Special Cost Centers	338,405	35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,519,820	40
41	Income before Income Taxes (line 30 minus line 40)**	145,587	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 145,587	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

**** Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Provena St. Joseph Center

0041871

Report Period Beginning:

1/31/03

Ending:

12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,615	1,848	\$ 70,582	\$ 38.19	1
2	Assistant Director of Nursing	1,808	2,200	52,311	23.78	2
3	Registered Nurses	16,952	18,261	341,967	18.73	3
4	Licensed Practical Nurses	20,805	22,085	384,242	17.40	4
5	Nurse Aides & Orderlies	70,759	75,938	736,978	9.70	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,536	5,126	52,855	10.31	8
9	Activity Director	1,991	2,151	26,137	12.15	9
10	Activity Assistants	3,854	4,091	35,983	8.80	10
11	Social Service Workers	3,350	3,779	51,657	13.67	11
12	Dietician					12
13	Food Service Supervisor	3,928	4,335	62,839	14.50	13
14	Head Cook	7,270	7,875	68,932	8.75	14
15	Cook Helpers/Assistants	18,569	19,826	134,855	6.80	15
16	Dishwashers					16
17	Maintenance Workers	6,685	7,689	85,647	11.14	17
18	Housekeepers	9,457	10,714	80,447	7.51	18
19	Laundry	11,665	13,427	107,694	8.02	19
20	Administrator	1,936	2,080	68,612	32.99	20
21	Assistant Administrator					21
22	Other Administrative	1,713	1,900	23,482	12.36	22
23	Office Manager					23
24	Clerical	5,523	5,927	66,274	11.18	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	3,779	4,003	53,367	13.33	33
34	TOTAL (lines 1 - 33)	196,195	213,255	\$ 2,504,861 *	\$ 11.75	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	136	\$ 10,045	35
36	Medical Director	\$960/mth	11,600	36
37	Medical Records Consultant	31	1,539	37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	23	1,323	44
45	Social Service Consultant	14	805	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	204	\$ 25,312	49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	96	\$ 3,864	50
51	Licensed Practical Nurses	1,537	57,945	51
52	Nurse Aides	236	5,671	52
53	TOTAL (lines 50 - 52)	1,869	\$ 67,480	53

Facility Name & ID Number Provena St. Joseph Center# 0041871Report Period Beginning: 1/31/03Ending: 12/31/03**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Teresa Parsek</u>	<u>Administrator</u>		\$ <u>68,612</u>	<u>Workers' Compensation Insurance</u>	\$ <u>44,009</u>	<u>IDPH License Fee</u>	\$ _____	
<u>Other</u>	<u>Other Admin</u>		<u>89,756</u>	<u>Unemployment Compensation Insurance</u>	<u>14,838</u>	<u>Advertising: Employee Recruitment</u>	_____	
				<u>FICA Taxes</u>	<u>173,490</u>	<u>Health Care Worker Background Check</u>	_____	
				<u>Employee Health Insurance</u>	<u>244,465</u>	<u>(Indicate # of checks performed <u>34</u>)</u>	_____	
				<u>Employee Meals</u>	_____		_____	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>	_____	<u>Dues & Subscriptions:</u>	_____	
					_____	<u>Advertising and Public Relations</u>	<u>20,551</u>	
				<u>Other Benefits</u>	<u>135,464</u>		_____	
					_____	<u>Home Office Allocation</u>	<u>5,405</u>	
					_____		_____	
				<u>Home Office Allocation</u>	<u>42,011</u>	<u>Less: Public Relations Expense</u>	(_____)	
					_____	<u>Non-allowable advertising</u>	<u>(12,399)</u>	
					_____	<u>Yellow page advertising</u>	(_____)	
					_____		_____	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>158,368</u>	TOTAL (agree to Schedule V, line 22, col.8)	\$ <u>654,277</u>	TOTAL (agree to Sch. V, line 20, col. 8)	\$ <u>13,557</u>	
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>Miscellaneous</u>			\$ <u>30,907</u>			\$ _____	<u>Out-of-State Travel</u>	\$ _____
<u>Corp Service Fee</u>			<u>82,802</u>			_____		_____
<u>Mgmt Fee</u>			<u>264,509</u>			_____	<u>In-State Travel</u>	<u>7,474</u>
<u>Mgmt Fee Interest</u>			<u>196,279</u>			_____		_____
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>574,497</u>			_____		_____
(Attach a copy of any management service agreement)						_____	<u>Seminar Expense</u>	_____
C. Professional Services						_____		_____
Vendor/Payee	Type		Amount			_____	<u>Home Office Allocation</u>	<u>4,330</u>
<u>Consulting</u>	<u>Various</u>		\$ <u>1,539</u>			_____	<u>Entertainment Expense</u>	(_____)
<u>Consulting</u>	<u>Various</u>		<u>1,323</u>			_____		_____
<u>Consulting</u>	<u>Various</u>		<u>805</u>			_____	TOTAL (agree to Sch. V, line 24, col. 8)	\$ <u>11,804</u>
<u>Consulting</u>	<u>Various</u>		<u>10,045</u>			_____		_____
<u>Consulting</u>	<u>Various</u>		<u>900</u>			_____		_____
<u>Legal</u>	<u>Various</u>		<u>3,860</u>			_____		_____
<u>Consulting</u>	<u>Various</u>		<u>28,437</u>			_____		_____
<u>Consulting</u>	<u>Various</u>		<u>58,464</u>			_____		_____
<u>Purchased Service</u>	<u>Various</u>		<u>60</u>			_____		_____
<u>Purchased Service</u>	<u>Various</u>		<u>1,804</u>			_____		_____
<u>Purchased Service</u>	<u>Various</u>		<u>398</u>			_____		_____
						_____		_____
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$ _____		_____
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ <u>107,635</u>			_____		_____

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Provena St. Joseph Center

0041871

Report Period Beginning: 1/31/03

Ending: 12/31/03

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. 5135 - Life Service Network
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Yes If YES, what is the capacity? 120
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 982 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 65,700
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$???
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: KPMG The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. not issued yet
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

Provena St. Joseph Center
0041871
Attachment for Related Facilities
12/31/2003

Related Nursing Homes

<u>Facility Name</u>	<u>City</u>
Provena Our Lady of Victory	Bourbonnais
Provena Pine View Care Center	St. Charles
Provena Geneva Care Center	Geneva
Provena Cor Mariae Center	Rockford
Provena St. Joseph Center	Freeport
Provena McAuley Manor	Aurora
Provena St. Anne Center	Rockford
Provena Villa Franciscan	Joliet
Provena Heritage Village	Kankakee

Related Business Entities

<u>Facility Name</u>	<u>City</u>	<u>Notes</u>
Provena Clinics		Physician's Clinics
Provena Fortin Villa Learning Center	Bourbonnais	Childrens Center
Provena Fox Knoll	Aurora	Retirement Community
Provena Health	Frankfurt	Parent Company
Provena Home Care		Home Health
Provena Home Equipment		Home Equipment
Provena Hospice		Hospice
Provena Hospitals		Hospital
Provena Laverna Terrace	Avilla, IN	Independent Living
Provena Meadowview Lodge	Kankakee	Supportive Living
Provena Senior Services	Mokena	Management Company
Provena Senior Services Pharmacy	Kankakee	Pharmacy
Provena St. Joseph Adult Day Center	Freeport	Adult Day Care
Provena St. Mary's Adult Day Center	Kankakee	Adult Day Care
Provena St. Vincent	Freeport	Community Living
St. Anne's Place	Rockford	Independent Living

Category	Item	Value	Unit
General Services	Administrative Services	100.00	USD
	Information Technology	250.00	USD
	Facilities Management	150.00	USD
	Security Services	75.00	USD
	Legal Services	120.00	USD
	Accounting Services	90.00	USD
	Marketing Services	110.00	USD
	Consulting Services	130.00	USD
	Training Services	80.00	USD
	Other Services	60.00	USD
Personnel	Salaries	1,200.00	USD
	Benefits	300.00	USD
	Travel	150.00	USD
	Per Diem	75.00	USD
	Contract Labor	200.00	USD
	Temporary Help	100.00	USD
	Union Dues	50.00	USD
	Professional Fees	120.00	USD
	Consulting Fees	90.00	USD
	Other Personnel	60.00	USD
Equipment	Computer Equipment	500.00	USD
	Office Equipment	300.00	USD
	Transportation	200.00	USD
	Communication	100.00	USD
	Medical Equipment	150.00	USD
	Construction Equipment	120.00	USD
	Tools	80.00	USD
	Other Equipment	60.00	USD
	Repairs	40.00	USD
	Maintenance	30.00	USD
Materials	Construction Materials	400.00	USD
	Office Supplies	200.00	USD
	Medical Supplies	150.00	USD
	Food and Beverage	100.00	USD
	Printing	80.00	USD
	Postage	60.00	USD
	Travel	50.00	USD
	Other Materials	40.00	USD
	Repairs	30.00	USD
	Maintenance	20.00	USD
Utilities	Electricity	100.00	USD
	Gas	80.00	USD
	Water	60.00	USD
	Telephone	50.00	USD
	Internet	40.00	USD
	Other Utilities	30.00	USD
	Repairs	20.00	USD
	Maintenance	10.00	USD
	Other Utilities	10.00	USD
	Other Utilities	10.00	USD
Total	Grand Total	5,000.00	USD
	Subtotal	4,500.00	USD
	Net Income	500.00	USD
	Profit Margin	10.00%	%
	Operating Ratio	90.00%	%
	Current Ratio	1.50	Ratio
	Debt to Equity Ratio	0.50	Ratio
	Return on Assets	5.00%	%
	Return on Equity	10.00%	%
	Other Financial Ratios	1.00	Ratio